# INTEGRATED PLAN PUBLIC INPUT
# LINKED TO INTEGRATED PLAN GOALS, OBJECTIVES AND STRATEGIES

This document follows the National HIV/AIDS Strategy (NHAS) Goals and includes input and updates from:

- The Florida Department of Health (FDOH) in Tallahassee – red/**red boldface.**
  - *The wording of the Goals, Objectives, and Strategies as received from Tallahassee are subject to editing by JIPRT and staff.*
- Miami-Dade County Integrated Plan community engagement responses – black**/black boldface:**
  - *Ryan White Program Client Focus Groups:* Clients over 55 years old; Clients under 55 years old; and Haitian clients (conducted in Creole).
  - *FDOH Workgroups*: Florida Black HIV/AIDS Coalition (formerly, Black Treatment Advocates Network); Hispanic Initiative (Iniciativa Hispana) (conducted in Spanish); Pre-Exposure Prophylaxis (PrEP) Workgroup; The Miami Collaborative MSM Workgroup; Transgender Tenacity Power; and Youth Health.
  - *Other*: Community Coalition Roundtable; Positive People Network, Inc.; Pridelines Hispanic Support Group (conducted in Spanish); Survey Monkey Survey
- Joint Integrated Plan Review Team input from May 9, 2022 JIPRT meeting – blue/**blue boldface.**

This is a working document, subject to change before August 2022.

General Comments:

1. More coordination is needed to ensure Integrated Planning does not revert back to bigger and better silos.
2. Objectives need to be quantifiable.
3. Customer service skills and standards should be addressed at all levels.
4. Reword Objectives to reflect percentage increase vs. a specific number; objectives should be written specific to our EMA.

# NHAS Goal 1: Prevention of New HIV Infections

## OBJECTIVE 1.1:
## BY DECEMBER 31, 2025, INCREASE THE PERCENTAGE OF PERSONS WHO KNOW THEIR HIV STATUS FROM 86% (2019) TO 90%.

Strategy 1.1.1: Implement HIV, HCV, and Syphilis screenings as part of routine medical care in all health care settings, including urgent care centers, FQHCs, small clinics, public hospitals, and emergency departments.

Activity 1.1.1a. Strong community support for routine HIV and sexually transmitted infection (STI) testing.

1. Make it more frequent.
2. Make it easier.
3. Reduce stigma associated with being tested in an HIV-provider context.
4. Increase funding for HIV testing in hospitals, health clinics, and urgent care centers.
5. Increase testing among non-HIV providers and expand to new providers.
6. Coordinate HIV testing with Hepatitis testing (FDOH/Jackson).
7. Focus on priority populations.
8. Secure funding for more STD testing, including home testing and follow up lab confirmatory tests.
9. HIV testing must include pre- and post-testing counseling components, this is particularly challenging in the hospital setting; Jackson ER serves approximately 3,000 people per month – post-test counseling is offered for those testing positive; post-test counseling is offered to those testing negative *if* the person contacts the hospital.
10. Consider simplified messaging and "old-fashioned" (1980s) counseling – 4 key points any healthcare worker can deliver.

Strategy 1.1.2: Reduce stigma in communities around HIV testing.

Activity 1.1.2a. Have after-hours STI and HIV testing in non-HIV settings.

Activity 1.1.2b. Need to provide at-home testing kits for HIV and STI.

1. Need to set a goal on the return rate for home testing. What is the benchmark?
2. Need to increase the number of home tests distributed and completed.

Activity 1.1.2c. Have HIV testing in schools.

1. Involvement of Children's Trust, parents, and parent groups.
2. Hold general health fairs at schools including HIV education.
3. Incorporate HIV education into general health education.

Strategy 1.1.3: Reduce stigma among health care settings around HIV testing.

Note: See above, Strategy 1.1.2. This strategy requires re-wording for clarity.

Strategy 1.1.4: Reduce stigma among correctional settings around HIV testing.

Activity 1.1.4a. Prisoners at Dade Correctional Institution say, "it's not getting the test, it's getting the pills," that brings stigma to prison.

1. What control does FDOH or RWP have over the Florida Department of Corrections?

**OBJECTIVE 1.2:**
**BY DECEMBER 31, 2025, REDUCE THE RATE OF HIV TRANSMISSIONS DIAGNOSED ANNUALLY FROM 22.7 (2019) TO XX.**

Strategy 1.2.1: Expand routine HIV, HCV, and Syphilis screening in emergency departments as part of medical care.

Note: See Strategy 1.1.1.

Strategy 1.2.2: Ensure health care providers are complying with the opt-out HIV and STI screening law for pregnant women.

1. Partner with reproductive justice organizations (Planned Parenthood, etc.)
2. No other community input on this issue; however, this was a major initiative in the 2017-2021 Integrated Plan.

Strategy 1.2.3: Increase awareness among women of childbearing age about HIV testing and perinatal prevention strategies.

1. Partner with reproductive justice organizations (Planned Parenthood, etc.)
2. No other community input on this issue; however, this was a major initiative in the 2017-2021 Integrated Plan.
3. Coordinate with Healthy Start.
4. Ensure pregnant women are getting prenatal care; HIV testing is effective among women who are in prenatal care.

**OBJECTIVE 1.3:**

**BY DECEMBER 31, 2025, EXPAND THE IMPLEMENTATION OF PREVENTION INTERVENTIONS IN FLORIDA (E.G., PREP, PEP).**

Strategy 1.3.1: Ensure access to and availability of pre-exposure prophylaxis (PrEP).

1. PrEP for sero-discordant couples -- When you get a positive test, how do you get the partner tested and on PrEP (if appropriate)?
2. If a person tests positive and gets into the Ryan White Program (RWP) so their medical care is paid, who pays for PrEP for their negative partner?
3. Individualized and targeted PrEP messaging, including "people who look like us" is needed for:
    a. Youth
    b. Women
    c. Trans persons
    d. MMSC
    e. Sex Workers
4. FDOH offers FREE startup PrEP for first 30 days, then what?
    a. Is it understood by providers how to pay for PrEP?
    b. What are payment options for pills vs. injectables?
    c. Need to understand RWP Part A/Minority AIDS Initiative (MAI) cannot pay for PrEP.
5. More FREE PrEP.
6. JIPRT raised question again of how to pay for PrEP.
7. Need culturally appropriate messaging around PrEP.
8. Providers need education on PrEP.

Strategy 1.3.2: Ensure access to and availability of post-exposure prophylaxis (PEP).

1. Need to fast-track nPEP through FDOH.
2. The process must be streamlined to ensure access within 72 hours. What happens on weekends or holidays?

Strategy 1.3.3: In counties with an approved ordinance, ensure access to syringe service programs (SSPs) and harm reduction services.

Note: There were no community comments in this area. Note that in Miami, we have the Infectious Disease Elimination Act (IDEA Exchange) needle exchange program in place, and one of our MAI subrecipients is using this as an access point to its MAI HIV services.

**OBJECTIVE 1.4:**
**EXPAND CULTURALLY APPROPRIATE OUTREACH AND MESSAGING CONCERNING HIV PREVENTION, TESTING, AND TREATMENT.**

1. Messaging at Miami-Dade International Airport to alert newcomers to Miami about testing and treatment.
2. More messages targeted toward women – HIV testing needs to be de-stigmatized among people who only think of it as a male-to-male sexual contact (MMSC) thing.
3. Messages in Spanish and Creole must be more than just translations of English messages.
4. Must step up outreach
    a. Whatever happened to case finding and street outreach? Or church outreach? Outreach is not just chasing lost to care.
    b. Health Resources and Services Administration Policy Clarification Notice (HRSA PCN) 16-02 allows for RWP outreach funding for communication and active involvement.
    c. Can't just wait for people to drift in for treatment, especially for minority populations.
5. Use multiple social media and dating app platforms for communication (Instagram, TikTok, YouTube, Grindr, Squirt, etc.)
6. Target the undocumented population with information about specific resources available to them and for which they are actually eligible.
7. More education about HIV in general (to reduce stigma associated with testing and treatment).

## NHAS Goal 2: Improve HIV-Related Health Outcomes of People with HIV

### OBJECTIVE 2.1:
### BY DECEMBER 31, 2025, INCREASE THE PERCENTAGE OF PERSONS WITH NEWLY DIAGNOSED HIV LINKED TO CARE IN 7 DAYS FROM 56.9% (2019) TO 70%.

Strategy 2.1.1: Provide same-day or rapid start of antiretroviral therapy.

1. "What do we do when we come in for testing, and then they tell us we can't get you in care because you don't live here?"
2. Community members complain that the fast-track Test and Treat/Rapid Access (TTRA) process does not take the mental health needs of newly-diagnosed into account.
3. Have a similar protocol in place for STIs as well as HIV.
4. Need to make sure clients know mental health services are available on the same day as TTRA – with non-threatening and non-judgmental messaging.
5. We are doing well in messaging on medical diagnoses; messaging on behavioral interventions/resources is lacking.
6. Consider a contingency management approach; reward systems/incentives work well; respond in a productive way.

Strategy 2.1.2: Improve linkage to HIV health care within 30 days for all persons who test positive for HIV.

1. Including mental health services. Note: Respondents acknowledge that getting behavioral health care carries its own stigma.
2. Hire more Peer Educators to communicate test results to newly-diagnosed.
3. Make sure all who test positive are offered mental health services; revise messaging around mental health service availability – consider the feelings of newly diagnosed persons.

Strategy 2.1.3: Work to reduce the average number of days to link persons to HIV care in Florida.

1. See 2.1.2, above.
2. The IDEA Exchange offers same-day linkage to care, like TTRA.
3. Again, mental health messaging and availability must be made to all clients as a matter of initial visit and follow up protocols.
4. Consider limitations of funding streams; Part A does not pay for services for negative partners; and not all services are covered by Medicaid, for instance.

**OBJECTIVE 2.2:**
**BY DECEMBER 31, 2025, INCREASE THE PERCENTAGE OF PWH RE-ENGAGED IN CARE FROM XX TO XX. (FDOH IS WORKING ON METRICS FOR THIS AND MAY CHANGE).**

Strategy 2.2.1: Implementation of Data-2-Care strategies

Note: No community input on this issue; however, "Data to Care" was a strategy in the 2017-2021 Integrated Plan.

Strategy 2.2.2: Identify and address barriers for people who have fallen out of care.

Note: No community input on this issue; note that retention was a concern of the 2017-2021 Plan.

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**OBJECTIVE 2.3: BY DECEMBER 31, 2025, INCREASE THE PERCENTAGE OF PWH RETAINED IN CARE FROM 72.2% (2019) TO 85%.**
*Note: The Retained in Medical Care (RiMC) percentages in Miami-Dade for the most recent RWP CQM Performance Report Card are 73% for clients receiving MCM services and 86% for clients receiving OAHS.*

Strategy 2.3.1: Enhance support for medication and treatment adherence.

1. Peers want to be more involved in client care, not just a "token person with HIV on the staff."

Strategy 2.3.2: Develop and implement effective, evidence-based, or evidence-informed interventions and supportive services that improve retention in care.

Note: The RWP is currently engaged in several Quality Improvement (QI) initiatives directed toward improved retention in care. Retention was a major concern of the last Integrated Plan.

Strategy 2.3.3: Ensure care systems include access to behavioral health services.

1. Participants noted that seeking and participating in behavioral health services is itself a source of stigma.

**Strategy 2.3.4: Improve scope, quality and training of Medical Case Managers and Peers**

1. RWP Medical Case Managers (MCMs) get trained and assist in getting clients help outside the agency –
    a. "I have needs that my MCM doesn't know where to get help for and I end up relying on people in the waiting room for information."
    b. Ignorance is a common complaint – why do clients know more about services and HIV than MCM? (Three RWP clients in one group did not know bus passes existed.)
2. MCMs need to develop a relationship with clients and not just act as data entry clerks.
3. Peers need more education and better pay
    a. Move beyond just being buddies.
    b. Don't want to just be a token employee to show "we hire people with HIV."
4. More competent/understanding people need to be hired at AIDS Drug Assistance Program (ADAP) sites and by RWP subrecipients.
5. Need a system to help MCM keep up to date address, phone, email of clients (avoid losing track of clients).
6. Can the Provide database be set to alert MCM for upcoming appointments (or it is just reactive)? Set alerts:
    a. This client needed housing last month – did they get housing?
    b. This client needs food on a regular basis – are they connected to food bank?
    c. Are there other resources that could help?

**OBJECTIVE 2.4:**
**INCREASE THE CAPACITY OF THE PUBLIC HEALTH, HEALTH CARE DELIVERY SYSTEMS, AND HEALTH CARE WORKFORCE TO EFFECTIVELY IDENTIFY, DIAGNOSE, AND PROVIDE HOLISTIC CARE AND TREATMENT FOR PEOPLE WITH HIV.**

Strategy 2.4.1: Develop and implement a medical student ambassador program.

Strategy 2.4.2: Develop and implement a statewide peer navigation model.

1. Participants complain that there is no more peer-led "buddy/companion" program.

Strategy 2.4.3: Provide resources and support technical assistance to expand workforce and systems capacity to provide or link individuals to culturally competent care.

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**OBJECTIVE 2.5:**
**EXPAND CAPACITY TO PROVIDE WHOLE-PERSON CARE TO OLDER ADULTS WITH HIV AND LONG-TERM SURVIVORS.**

Strategy 2.5.1: Develop a promotional PSA and associated social media messaging on healthy aging

1. Create and disseminate self-care messages for older adults ("older people have sex, too!")

Strategy 2.5.2: Engage with partner agencies and program to address the multitude of aging and chronic conditions affecting persons with HIV over the age of 50.

1. Do "Aging HIV Community" needs assessments to determine special social, mental health, and pharmacy issues of older people with HIV.
2. Develop special mental health services for older persons with HIV – dealing with isolation, loneliness, depression, problems with adult children, more expenses and less money.
3. Help older persons with HIV in the process of transitioning from RWP to Medicare. Older focus group and survey participants felt they had no help making the transition. Many did not know their pharmacy options. Many did not know how to deal with co-pays. Reportedly, MCMs did not help at all.
4. Older persons with HIV complain that they are, "only being treated according to their HIV," their non-HIV aging problems are ignored or not paid for. "Been navigating RWP for years, now I have to navigate a whole bunch of services I didn't know about."

Strategy 2.5.3: Assess polypharmacy issues for aging populations with HIV.

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**OBJECTIVE 2.7:**
**EXPAND CAPACITY TO PROVIDE WHOLE FAMILY CARE TO WOMEN WITH HIV**

1. Women with HIV have more complex problems because they often have childcare duties as well. Who's paying attention to the whole household?
2. Women need more information on PrEP. Many don't know about it or believe, "PrEP is not made for women.". For women who are the "negatives" in sero-discordant couples, nobody pays for PrEP.
3. HIV stigma is higher among women.
4. Women with HIV are often discriminated against in provider offices.
5. Women need more economic support.

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**OBJECTIVE 2.7:**
**CONCENTRATE ON REDUCING VIRAL LOAD (VL) SUPPRESSION**

6. Ramp up messaging to persons with HIV: know your numbers, track your progress.
7. Undocumented persons need quick viral load tests to keep from being stigmatized.
8. Note: The 2017-2021 Integrated Plan had an extensive set of objectives, strategies, and activities related to VL suppression. These should be included in the 2022 Plan as well.

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# NHAS Goal 3: Reduce HIV-Related Disparities and Health Inequities

## OBJECTIVE 3.1:
## REDUCE HIV-RELATED STIGMA AND DISCRIMINATION

### Strategy 3.1.1: Ensure that health care professionals and front-line staff are educated and trained on stigma, discrimination, and unrecognized bias toward priority populations.

1. Significant reports on microaggressions, discriminatory language by service personnel (front desk, case managers, doctors), call for training.
2. *Make sure the first point of care is not the point of lost to care!*
3. Overall cultural sensitivity training and enforcement of culturally sensitive standards is needed.
4. Why are doctors and case managers allowed to say homophobic things or make gay jokes?
5. Understanding the importance of and using correct pronouns.
6. Addressing ethnic/racial/gender biases. Women, transgendered persons get treated especially badly.
7. Hispanics get treated first/better by Hispanics; African-Americans get treated first/better by African-American, etc. in healthcare settings (either real or perceived biases).
8. Transgender clients get treated badly.

### Strategy 3.1.2: Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.

1. This area was not addressed by any of the community groups; however, this has been a major activity in the implementation of the 2017-2021 Integrated Plan and should be continued in the 2022-2026 Plan.

### Strategy 3.1.3: Work with communities to reframe HIV service delivery and HIV-related messaging to prevent stigma among people or behaviors.

1. Educate adults about HIV – it's not just about being gay, it's about accepting people with HIV.
2. HIV is not like cooties – you don't catch it from being with people with HIV.
3. HIV is not a death sentence – the people you see are not dying, they are living with HIV.
4. Latin and Creole communities need special messages – cultural biases are serious business.
5. Kids need education – not just safe sex education in schools, but in churches, the "Y".

### Strategy 3.1.4: Address social and structural determinants of health and co-occurring conditions that impede access to HIV services and exacerbate HIV-related disparities.

1. When will people start to get serious about housing? This is a major co-occurring condition.
    a. Not enough housing available.
    b. Housing discrimination exists based on sexual/gender identification, race, and ethnicity, and language.
    c. Getting into housing costs are very high, such as furniture, moving trucks, etc.
    d. Need short-term housing while people are on the Housing Opportunities for person with AIDS (HOPWA) waiting list, or need short-term housing (under 2 years).
        i. What is the HOPWA Program doing for people while they are waiting for long-term housing?
        ii. Do people know about short term assistance?

**Strategy 3.1.5: Create a Transgender task force to identify and remediate unmet needs.**

1. Hire/train transgender advocates and work with advocates outside your agency.
2. Training is needed to de-stigmatize transgender issues at agencies – all levels – front desk to MCM to doctors.
3. Trans Tenacity, "We are tired of taking surveys and not seeing any change."
4. Connect persons to name change clinics; explore funding for name change clinics.
5. Establish more transgender support groups as a "safe space."

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**OBJECTIVE 3.2:**
**BY DECEMBER 31, 2025, REDUCE THE ANNUAL RATE OF NEW HIV DIAGNOSES AMONG THE BLACK POPULATION FROM 52.9 (2019) TO 47.1 [This work element should be moved to NHAS Goal 1, Prevention, focusing on disparity populations]**

Strategy 3.2.1: Identify and develop interventions to improve health outcomes among black women.

Strategy 3.2.2: Identify and develop interventions to improve health outcomes among black men.

Strategy 3.2.3: Develop and promote culturally appropriate HIV prevention and care activities.

Strategy 3.2.4: Expand community engagement efforts to address service delivery and prevention gaps.

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**OBJECTIVE 3.3:**
**BY DECEMBER 31, 2025, REDUCE THE ANNUAL RATE OF NEW HIV DIAGNOSES AMONG THE HISPANIC POPULATION FROM 29.2 (2019) TO 25.9. [This work element should be moved to NHAS Goal 1, Prevention]**

Strategy 3.3.1: Identify and develop interventions to improve health outcomes among Hispanic men.

Strategy 3.3.2: Develop and promote culturally appropriate HIV prevention and care activities.

Strategy 3.3.3: Create funding opportunities that specifically address PrEP uptake.

Strategy 3.3.4: Expand community engagement efforts to address service delivery and prevention gaps.

Note: The FDOH draft goals, objectives, and strategies do not include ethnic, sexual preference or gender disparities in populations receiving RWP Part A/MAI services. The NHAS GOAL 3 section of the 2017 IP contains numerous goals to identify disparity groups in care and provide remedies. Staff recommends that OBJECTIVE 3.2 and OBJECTIVE 3.3 be moved to the Prevention section, and that disparity populations be identified for attention in Care and Treatment populations.

The focus on Hispanics and Blacks does not account for the Haitian population in Miami-Dade. Staff recommends that disparity populations for both retention in care and viral load suppression take this population into account.

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## NHAS Goal 4: Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and interested parties

This goal was the most frequently vocalized area of concern in the community input sessions and stakeholder surveys. The items listed below are drawn from these expressions. Staff feels that the objectives drafted by the State need considerable revision to make them more concrete. The JIPRT may choose to address the wording of these objectives and strategies, pursuant to suggesting revisions to the State, or may choose to allocate the community concerns into the existing objectives and strategies.

1. Coordinate data sharing between RWP Parts A, B, D, F; General Revenue (GR); and ADAP so that everybody knows what is going on.
2. Coordinate data sharing between the RWP and Medicaid.
3. "De-silo" treatment – subrecipient agencies don't "refer out" if they are afraid the clients will be lost when they go to another subrecipient.
4. Case managers need to know about non-RWP services and share those resources with clients so clients can make better use of them.
5. Clients have no idea where to go for help.
    a. Nobody knows that aidsnet.org exists as a resource. Clients have no idea where to go for help.
    b. Case managers are ignorant about anything that they don't provide in their own agencies.
6. "Status neutral" means treating the whole person, not just HIV. How come we don't treat the whole person? Need more required training on the status-neutral approach to care.
7. Mental health services are available beyond the RWP. Why are clients not being made aware?
8. Fund peer support networks that cut across funding boundaries and providers – newly diagnosed? STI? Transgender?
9. Substance abuse services are available – why are they only residential?
10. Need a community information hub, for all programs, for all clients.
11. Youth resources are lacking.
12. RWP needs to link with other Community Based Organizations (CBOs) to provide services to the whole client.
13. Other wrap-around services are needed: housing, support groups, transportation.
14. Why do we exclude faith-based services from our referral networks when they are free to everybody?
15. We need to get the word out to the community that there are services beyond the Ryan White Program.
16. People don't know what services exist (RWP, ADAP, etc.). We have services that are not being used because people don't know where to go.
17. It isn't a working system of care if nobody knows how to navigate it.
18. Clients who go to [name of outside agency] are treated [poorly] when the agency finds out they have HIV. We need to make cultural sensitivity a requirement to do business as a social service agency in Miami-Dade.

**OBJECTIVE 4.1:**
**BY DECEMBER 31, 2025, INTEGRATE HIV, STI, AND VIRAL HEPATITIS PROGRAMS TO ADDRESS FACTORS IMPACTING THESE SYNDEMICS.**

Strategy 4.1.1: Integrate awareness and education into outreach and services across the syndemics.

Strategy 4.1.2: Assess funding, data, workforce capacity, and programmatic barriers to effectively address the syndemics.

Strategy 4.1.3: Coordinate and align strategic planning efforts on HIV, STIs, and viral hepatitis across programs.

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**OBJECTIVE 4.2:**
**IMPROVE PRIVATE-PUBLIC-COMMUNITY PARTNERSHIPS TO IDENTIFY AND SCALE UP BEST PRACTICES AND ACCELERATE HIV ADVANCES.**

Strategy 4.2.1: Adopt approaches that incentivize the scale up of effective interventions among academic centers, health departments, community-based organizations, allied health professionals, people with HIV and their advocates, the private sector, and other partners.

Strategy 4.2.2: Expand opportunities and mechanisms for information sharing and peer technical assistance within and across jurisdictions to move effective interventions into practice more swiftly.

Strategy 4.2.3: Develop and optimize collaborative multi-agency and multi-sectoral approaches and strategies to address emergent and evolving challenges facing persons of all ages living with HIV.

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**OBJECTIVE 4.3:**

Strategy 4.3.1: Streamline and harmonize reporting and data systems to reduce burden and improve the timeliness, availability, and usefulness of data.

Strategy 4.3.2: Monitor, review, evaluate, and regularly communicate progress on the National HIV/AIDS Strategy.

Strategy 4.3.3: Strengthen monitoring and accountability for adherence to requirements, targets, and goals by funded partners

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